Bulletin HC-48 (revised)

LICENSING OF UTILIZATION REVIEW COMPANIES - §38A-226 ET AL, C.G.S.

June 9, 1994

Connecticut General Statute 38a-226 et al requires that any company, organization or other entity performing utilization review in Connecticut on or after October 1, 1992 must be licensed by the Commissioner.

Information on the format for license application is available from the Insurance Department. Requests should be sent to the attention of the Life & Health Division at the address listed below.

Companies should be sure that each application is complete with all necessary supporting materials. Applications will not be considered until all required information is submitted. Upon satisfactory review of the application, the company will be notified that a license will be issued upon receipt of the $2500 license fee. All checks must be made payable to the Treasurer – State of Connecticut.

Companies should also be aware that licenses must be renewed *annually*.

The Department has received inquiries about exemption from licensing for companies which perform utilization review in a limited universe, for example, only in connection with workers' compensation coverage. The only exemptions provided by statute are those granted to 1) a federal agency, 2) an agent of the federal government (but only to the extent it provides services to the federal government), 3) an agency of the State of Connecticut, or 4) a hospital's internal quality assurance program (except if this program is associated with a health care financing program). The Department will not entertain requests to recognize an exemption on any other basis. Companies should also note that any material change in the information supplied in a request for licensure or renewal *must* be filed with the Commissioner of Insurance within 30 days of the change.

Robert R. Googins
INSURANCE COMMISSIONER

Utilization Review License Application

The format below must be followed in preparing an application for a license to conduct utilization review. Applications should be completed as directed, signed and acknowledged by the applicant's president or other duly authorized representative. Applications will not be considered complete until all required information is submitted.

ALL UTILIZATION REVIEW LICENSES EXPIRE ANNUALLY ON SEPTEMBER 30TH.

Name of Company: _____

Address: _____

_____

Telephone: _____ **Toll Free**: _____

Business Hours (eastern time**)** _____

Contact Person: _____ **Direct #:** _____

The following information is submitted as evidence of compliance with the minimum standards prescribed in §38a-226 et al of the Connecticut General Statutes and PA 97-99, as amended in support of the application for license of the above named company.

[Provide the information required for each of the following items in the order presented]

1. Describe the company's procedures for providing notification of its prospective and concurrent determinations regarding certification, and describe the steps taken to make them available to interested persons. Attach as Exhibit 1A examples of approval letters sent to enrollees and/or providers indicating where the required authorization number can be found. Attach as Exhibit 1B an example of the company's available description of its notification process.

2. Attach as Exhibit 2A sample copies of all denial letters sent to enrollees and/or providers. All notices of a determination not to certify an admission, service, procedure

or extension of stay must be in writing and include (1) the principal reasons for the determination; (2) the procedures to initiate an appeal or the name and telephone number of the person to contact with regard to the appeal and (3) the procedure to appeal to the Commissioner to initiate an external appeal. Such provision should indicate that:

a) the enrollee must first exhaust all of the utilization review company's internal appeals mechanisms;

b) the appeal must be filed with the Insurance Department within thirty (30) days of the utilization review company's final decision;

c) the external appeals process is not available to enrollees who are covered under a self-insured plan or to denials regarding workers compensation; and

d) the enrollee may contact the Connecticut Insurance Department at Post Office Box 816, Hartford, CT 06142-0816, Telephone (860) 297-3910.

3. Describe the appeal procedure within the utilization review company by which persons may seek review of the company's determinations not to certify an admission, service, procedure or extension of stay, and describe the steps taken to make available a written description of this procedure. Describe the company's procedure for a emergency or life threatening situations. State whether or not the company's procedures include a period of time within which an appeal must be filed and, if so, state what that period is. Attach as Exhibit 3A an example of the company's written description of it appeals procedure.

4. Describe the procedure by which the company assures that, on appeal, all decisions not to certify an admission, procedure, service or extension of stay is reviewed by a physician who is a specialist in the field related to the condition whenever the reason for the decision is based on medical necessity, including whether a treatment is experimental or investigational.

5. Describe the process by which the company's written clinical criteria and review procedures are developed, evaluated and revised, including how practitioners are involved in this process. Supporting material may be attached.

6. State the hours (in eastern time) during which the company's review staff is available by toll-free telephone. In addition, in accordance with the process established under Section 18 of PA 97-99 regarding an expedited review process (attached) please forward a completed expedited review form indicating two methods of communication.

7. State the number of nurses, practitioners and other licensed health professionals making utilization review decisions for the company and describe their professional qualifications. Supporting material may be attached.

8. State the time which the company allows following an emergency admission, service or procedure for an enrollee or his representative to notify the company and request certification or continuing treatment. Supporting material may be attached.

9. Describe the company's procedures to ensure compliance with applicable state and federal laws protecting the confidentiality of medical records. Supporting material may be attached.

10. Confirm that no person engaged in utilization review receives any compensation based on the number of certification denials.

11. Please complete and forward the attached survey.

12. (Optional) If the company has received accreditation by a utilization review accreditation organization, indicate by whom and when and the expiration date of such accreditation, if any.

Complete and sign the following acknowledgement

I, _____, _____
(PRINTED NAME) (TITLE)

of _____, hereby acknowledge that I have
(COMPANY)

read the foregoing request and attached materials, that the information provided is true and accurate and offered in support of this license application in accordance with §38a-226 et al, as amended by Public Act 97-99. I understand that any material changes in the information contained in this application must be filed with the Commissioner, as an amendment hereto, with thirty days of such change.

_____
(SIGNATURE)

_____
(DATE)

Utilization Review Survey

Name of Company: _____CT Lic. #: _____

Name of Person Completing Survey:_____
Title: _____
Telephone #: _____

Date Licensed to Perform Utilization Review in Connecticut: _____

1. Type of Utilization Review conducted: (check all that apply)

☐ Inpatient	☐ Mental Illness	☐ Vision
☐ Outpatient	☐ Substance Abuse	☐ Dental
☐ Workers Comp	☐ Chiropractic	☐ Other: _____
☐ Medicaid		_____

2. UR conducted in Connecticut for: (check all that apply)

☐ HMO _____
☐ Licensed Indemnity Insurance Company _____
☐ Single Employer Self-insured Plan _____
☐ Other:_____
_____

3. If more than 1 box checked in # 2 above, are procedures the same for all entities (i.e. protocols, authorizations and appeals processes)? _____
_____
If no, please explain _____
_____

4. How is the UR company reimbursed for services? _____
_____
_____

5. Describe the professional liability coverages maintained with respect to legal liability: _____
_____

6. Who in your organization has first contact with a request for authorization:
☐ Clerical ☐ Nurse ☐ Provider ☐ Other _____

Does that person have :

Authority to approve services? _____
Authority to deny services? _____
Authority to negotiate services?_____

7. Does the reviewer look at the coverage available under the individual's health contract to ensure that services are covered and policy maximums have not been reached prior to authorizing services? _____
_____

8. How are reviewers compensated? _____
_____

9. What training is provided to case reviewers? _____
_____
Is training given on an on-going basis? _____

10. How are reviewers evaluated for job performance? _____
_____

11. What is the average review time for pre-authorizations? _____

12. What is the time limit for filing an appeal?_____

13. Explain the internal appeals process: _____
_____
_____
_____

14. If appeals are handled on an external basis, describe how appeals reviewers are selected, and explain the contractual relationship between the UR company and the appeals reviewers, including compensation, availability for emergency appeals and adherence to confidentiality requirements: _____
_____
_____
_____
_____

15. How are emergency appeals handled? _____
_____
_____

16. Are medical providers available at all times to review emergency appeals?
_____

17. How are protocols determined?_____
_____
_____

18. Explain the process by which protocols are modified: _____
_____
_____
_____

19. If using protocols from outside sources, please identify: _____
_____
_____

20. Describe the data processing system employed for maintaining enrollee medical information used in the UR decision:_____
_____
_____
_____

21. Describe procedures and systems in place regarding confidentiality of individual patient information:_____
_____
_____

22. Has the UR company received URAC accreditation? _____

23. List all states where the company is currently licensed to perform UR: __
_____
_____
_____
_____
_____
_____

24. Have any market conduct examinations been conducted by any state regulatory authority? _____
If yes, please list state(s) and dates of examination:_____
_____
_____

25. Have any sanctions, fines, revocation, or restriction of licensure been imposed by any regulatory agency?_____
If yes, please explain: _____
_____
_____

26. Describe the organizational structure of the company, including parents, affiliates and subsidiaries:_____
_____
_____
_____
_____
_____

27: List all managed care organizations, as defined in §38a-478* that the utilization review company services in Connecticut:
_____
_____
_____
_____

28. List any utilization review services which the company has contracted out for services and the name and CT license # of such company providing the services: _____
_____
_____
_____
_____

* definition attached

“**Managed Care Organization**” as defined in §38a-478 means an insurer, health care center, hospital or medical service corporation or other organization delivering, issuing for delivery, renewing or amending and individual or group health managed care plan in this state.

“Managed Care Plan” as defined in §38a-478 means a product offered by a managed care organization that provides for the financing or delivery of health care services to persons enrolled in the plan through: (A) Arrangements with selected providers to furnish health care services; (B) explicit standards for the selection of participating providers; (C) financial incentives for enrollees to use the participating providers and procedures provided for by the plan; or (D) arrangements that share risks with providers, provided the organization offering a plan described under subparagraph (A), (B), (C) or (D) of this subdivision is licensed by the Insurance Department pursuant to chapter 698, 698a or 700 of the general statutes and that the plan includes utilization review pursuant to sections 38a-226 to 38a-226d, inclusive, of the general statutes, as amended by this act.

STATE OF CONNECTICUT
Expedited Review Process

The following standardized process has been developed pursuant to Section 18(e) of Public Act 97-99, as amended, to initiate a request for an expedited review to a Utilization Review Company.

It is to be utilized by the attending physician on behalf of an enrollee **admitted** to an acute care hospital, if the attending physician determines that the enrollee's life will be endangered or other serious injury could occur if the patient is discharged or if treatment is delayed.

1. Each utilization review company shall provide the Insurance Department with two (2) methods of communication to implement this process.

    - The first method of communication shall be by telephone.

    .

    - The second method shall be either by a telephone system with voice messaging (for recording purposes) or a fax (with a confirmation system) and will be used when the attending physician cannot get through the initial contact number. This back-up method would constitute a record of the fact that an expedited review request was made and start the three hour response clock.

    - The Insurance Department will keep a directory of all numbers from the utilization review companies and distribute them to each acute care hospital in Connecticut. **It is the obligation of the licensed utilization review company to keep the Department notified of any changes in these numbers. Failure to do so will be interpreted as an approval of the physician's request as the attending physician will be unable to make contact with the utilization review company.**

2. The attending physician shall contact the utilization review company by telephone with the initial request for expedited review.

    - If the request is approved on the initial telephone call, an authorization number must be given.

    - If the request is denied, the physician/patient will have the current statutory appeals process available to them. All denials must be followed-up in writing in accordance with current law.

    - If the utilization review company requests additional clinical information to complete its review, the utilization review company has three (3) hours to complete the review and make its determination once the attending physician has provided such information.

    - The attending physician must give two methods of communication for the utilization review company to respond.

3. Each utilization review company must have review staff available from 8:00 a.m. to 9:00 p.m., eastern standard time, 7 days per week, to process requests.

4. The 3 hour deemer shall not apply to requests initiated between 6:00 p.m. and 8:00 a.m., eastern standard time.

CONNECTICUT
Expedited Request Form

This form may be used by the **attending physician**, for a patient who is **admitted** to an acute care hospital, if the physician determines that the patient's life will be endangered or other serious injury or illness could occur if the patient in discharged or if treatment is delayed

Patient Information	Hospital/Provider Information
Name	Hospital Name
Address	Attending Physician
	Telephone
Insured Name	Fax Number
Insurer	Utilization Review Company
Identification #	
Relationship of Patient to Insured:	
☐ Self ☐ Spouse ☐ Dependent Child	

Specific Request (i.e. treatment or extension of length of stay)_____
_____
_____

Clinical Indication, Complication and/or Deviations from Standards:(please explain and note time observed))
_____
_____
_____

Current treatment plan: _____
_____
_____

_____
Signature of Attending Physician

_____/_____
Tel. # / Fax # of Attending Physician

_____
Date and Time of Request

NOTICE TO UTILIZATION REVIEW COMPANY:

Pursuant to Section 18(e) of Public Act 97-99, as amended by PA 97-8 June 18 Special Session, if no response is received after three (3) hours have passed since the provider sent the request and all information needed to complete the review, such request shall be deemed approved. Any determination not to certify the request for service, procedure or extension of stay must be in writing and include 1) the principal reasons for the denial, 2) the procedures to initiate an appeal of the determination or the name and telephone number of the person to contact with regard to the appeal and 3) the procedure to appeal to the Insurance Commissioner for an external appeal.

All determinations not to certify must be made by a licensed practitioner. Each utilization review company shall make review staff available from 8:00 a.m. to 9:00 p.m., eastern time to process requests.

Expedited Review Process

Company Name: _____

License #: _____

Methods of Communication*

First contact - Telephone Number: _____
(area code)

Second contact: _____
(areas code)

Please indicate whether second contact is: ☐ Telephone system with voice messaging; or

☐ Fax machine with confirmation system

***Note: Two methods of communication must be listed**

I hereby certify the company will have review staff available between 8:00 a.m. and 9:00 p.m., eastern standard time to process expedited review requests pursuant to Section 18(e) of Connecticut Public Act 97-99, as amended.

_____
(OFFICER SIGNATURE)

_____
(PRINTED NAME)

_____
(DATE)